PATIENT INFORMATION

DATE:_____ ARRIVAL TIME:_____ *REASON FOR VISIT:*_____

Have you been a patient here before? ☐ Yes ☐ No Is your visit reason ☐ Work Related ☐ Motor Vehicle Accident

Patient Name: _____ **Date of Birth:**_____ **SS#:**_____

Street Address: _____ On Cell or Home?
Best time to call? AM PM ANY

City: _____ **State:** _____ May we leave a detailed message? Y N

Zip: _____ **Home Phone:** ( )_____-_____

E-Mail: _____ **Cell Phone:** ( )_____-_____

Primary Care Physician:_____ **Phone:**_____**City**:_____

Preferred Language: _____ **Birth Sex:** M F

Race:†☐American Indian†☐Asian†☐African American†☐White†☐Other **Ethnicity:** ☐Hispanic/Latino ☐Non-Hispanic/Latino

Preferred Pharmacy:_____

Emergency Contact: _____ **Home Phone:** (_____)_____

Relationship: _____ **Cell Phone:** (_____)_____

(THESE NUMBERS MUST BE DIFFERENT THAN THE PATIENTS')

If the patient is under 18 years of age, please fill out following responsible party information:

Guarantor/Parent Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Please confirm that the Guarantor/Parent Billing Address is the same as the address listed above: Yes If not,
Please provide: _____

Survey: How did you hear about us (please circle): Building Sign Primary Doctor Family/Friend Employer Internet Search Facebook Newspaper Radio Other_____

Are we billing insurance today? ☐Yes ☐ No **No insurance** ☐

If yes, Insurance company?_____ **Group or Subscriber Number**: _____

Policy Holder' Name: _____**DOB:** _____